



An Atypical Presentation of Pelvic Inflammatory Disease in a Patient with Autism: A Case Report

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Abstract

Pelvic inflammatory disease can be an incredibly difficult condition to treat. The patient having a developmental disability such as autism can further complicate the matter. When numerous imaging studies, lab reports, and hospital admission have been pursued and symptoms persist, the situation begins to take the form of a novel clinical case. We present the case of an autistic woman who had persistent abdominal pain over the course of 5 years. After non-gynecologic causes of her pain were ruled out, she began treatment for pelvic inflammatory disease which she for the most part responded to. Questions about whether or not her pain was in part somatic or due to an uncomfortable intrauterine device are also discussed.

Keywords: Pelvic Inflammatory Disease; Autism; Depression; ADHD; Persistent Pelvic Pain; Gynecology

Introduction

Recent studies have shown that women with autism spectrum disorder have higher rates of menstrual problems, including irregular menstrual cycles, unusually painful periods (dysmenorrhea), and excessive menstrual bleeding [1]. This is further compounded by recent studies indicating that adolescents with autism and other developmental disabilities were less likely to visit the obstetrician-gynecologist or to use any form of hormonal contraception, including oral contraception, hormonal implants, and intrauterine devices [2]. Pelvic inflammatory disease is another gynecological condition which manifests as an infectious inflammation of the upper genital tract in females [3]. The majority of pelvic inflammatory disease cases are caused by *Neisseria gonorrhoeae*, *Chlamydia trachomatis*, and *Mycoplasma genitalium*; bacterial vaginosis is also common [3]. The diagnosis is made clinically in patients with cervical, uterine, or adnexal tenderness noted during a bimanual examination [3]. The majority of women with PID have either mucopurulent cervical discharge or evidence of WBCs on a microscopic evaluation of vaginal fluid [4]. If the cervical discharge appears normal and no WBCs are observed on the wet prep of vaginal fluid, a PID diagnosis is presumed unlikely [4]. Pelvic inflammatory disease is associated with fallopian tube inflammation, which can lead to infertility, ectopic pregnancy, and chronic pelvic pain [5]. This article will present the unique case of a patient with autism who had been having refractory bleeding due to pelvic inflammatory disease. Her gynecological issues were further complicated by dysmenorrhea which was being treated with an intrauterine device.

Case Presentation

The patient was a female in her thirties that had been diagnosed with autism. She was seen in the emergency room in the year 2024 for increasing intermittent epigastric pain that had been worsening over the course of five years. At that time she also was not able to keep any food down for the past two days. Following a laboratory workup, bedside ultrasound, and abdominal examination she was discharged with ondansetron. It was also noted at that time that she had an intrauterine device for the treatment of primary dysmenorrhea.

She followed up at a gastroenterology office the next month and was treated for gastroesophageal reflux disease. She had a HIDA scan ordered and tested for a potential infection of *Helicobacter Pylori*. The HIDA scan came back as normal. When she returned to the gastroenterology clinic 3 months later, they wanted her to continue taking esomeprazole and have a follow-up EGD.

A couple months later she presented to the emergency department for stabbing lower abdominal pain. She was crying and in severe distress. The pain on the abdominal exam was noted to be a severe



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Figure 1: CT of the abdomen and pelvis w/ contrast.

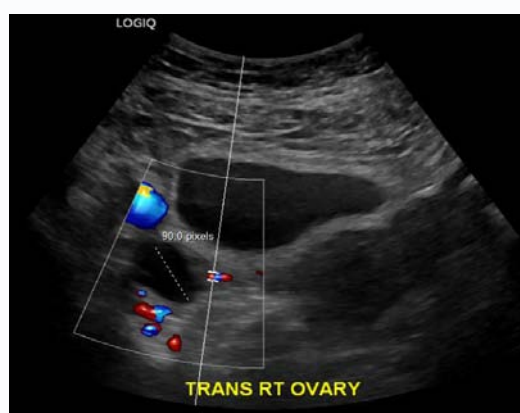


Figure 2: Pelvic ultrasound.

stabbing lower abdominal pain. Labs and swabs that were collected were negative with the exemption of leukocytosis. She had to be given IV morphine to control her pain. A CT of the abdomen with contrast was also negative (Figure 1). The provider also considered that the patient could have pelvic inflammatory disease given the severe pain on pelvic exam. The gynecologist that was consulted agreed with giving antibiotics.

Figure 1 depicts the CT of the abdomen and pelvis with contrast of the patient that was devoid of intra-abdominal pathology.

The patient was admitted to the hospital for the further treatment of her questionable pelvic inflammatory disease. The hospitalist thought this was likely more of a gastroenteritis but continued empiric antibiotics. She seemed to improve and was discharged on an antibiotic regimen a few days later.

After completing her antibiotic course, her pain resumed and she returned to the emergency department the next week for abdominal pain. The emergency physician considered a CT of the abdomen but had low suspicion for dangerous intra-abdominal pathology. A bedside pelvic ultrasound demonstrated normal ovaries and uterus. There was no free fluid in the pelvis or abnormal fluid collection to suggest a tubo-ovarian abscess.

She was then admitted to the hospital yet again for the second time that month. She was given a course of antibiotics and underwent a transvaginal ultrasound. The transvaginal ultrasound showed

the intrauterine device appropriately placed in the endometrium and a small right ovarian cyst (Figure 2). The patient was without abdominal pain at the time. Vaginosis, chlamydia, and gonorrhea swabs were negative for an acute infection. Despite being eligible to be discharged, the patient requested to be seen by a gynecologist for her intrauterine device to be removed. Following the removal, she was encouraged to take cyclobenzaprine, ibuprofen, and acetaminophen. She was then discharged from the hospital.

Figure 2 depicts the pelvic ultrasound the patient had that was normal apart from a simple cyst in the right ovary measuring approximately 2.1 cm.

Discussion

For the most part, the patient was compliant with her treatment regimens and following through for her medical appointments. Doctors had made due diligence to rule out other causes of abdominal pain such as various gastrointestinal pathologies. This pointed to none other than a gynecological cause for her issues. Her symptoms seemed to episodically resolve when she was treated with antibiotics in the hospital, but it was peculiar that she never even once tested positive for Chlamydia or Gonorrhea. She also had a levonorgestrel intrauterine device which is believed to reduce the risk of pelvic inflammatory disease due to the thickening of cervical mucus. She seemed to respond to the treatment of pelvic inflammatory disease but lacked numerous laboratory findings that are commonly associated with it. Additionally, on her transvaginal ultrasound, she was found to have a simple cyst on her right ovary. On a previous emergency room visit, she stated that her abdominal pain was more in the lower right abdomen. While the treatment for a simple ovarian cyst is supportive, there is no telling how much this cyst could have contributed to her pain. On her later stay she stated that she found her intrauterine device uncomfortable and had it removed by the gynecologist. Digital examination of the pelvic floor revealed normal contraction and relaxation of the musculature, thus ruling out pelvic floor myalgia. Despite the ultrasound showing appropriate placement of the intrauterine device, there may still be a likelihood that this could have indeed contributed to her pain and/or anxiety thus exacerbating her symptoms. Somatization of pain could also be an explanation of her symptoms. This becomes increasingly likely because in many of her physician encounters, she was always found with normal vital signs.

Conclusion

Treating primary dysmenorrhea can be quite difficult. When this is further complicated by autism, a patient can reasonably undergo significant difficulties. Pelvic inflammatory disease can add to the mix and present a unique clinical scenario for which there is much unknown. Further investigations must be made to establish working clinical protocols for perplexing gynecological conditions afflicting those with significant mental illnesses.

Statement of Informed Consent

Informed consent was obtained from the patient that was presented in the case report.

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